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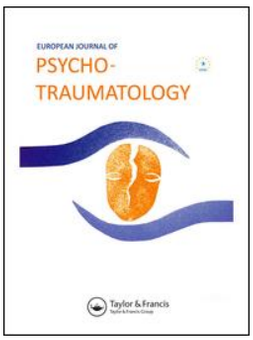

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LETTER TO THE EDITOR

Cautions and concerns about Huntjens et al.'s Schema Therapy for Dissociative Identity Disorder

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Dear Dr. Olff,

We respond to Huntjens, Rijkeboer, & Arnzt's (2019) paper, 'Schema therapy for Dissociative Identity Disorder (DID): Rationale and study protocol'. We welcome their recognition of the concerns expressed by dissociative disorders (DD) experts about the underdiagnosis, chronicity, and high costs associated with DID, and their call for increased treatment research on DID (Brand et al., 2019; Spiegel et al., 2013). As experts in treating and researching dissociation, we strongly support advances that ameliorate these patients' suffering. However, we have concerns about aspects of Huntjens et al.'s (2019) literature review, understanding of expert treatment recommendations, and methodology.

Huntjens et al. (2019) challenge the expert consensus staged model that prioritizes development of safety and stabilization of severe dissociative and PTSD symptoms prior to intensive trauma exploration (Brand et al., 2012; International Society for the Study of Trauma & Dissociation [ISSTD], 2011). They argue the staged approach may harm patients by delaying a focus on trauma and they provide a study protocol which we critique.

Huntjens et al. (2019) misunderstand the staged model of DID treatment: trauma and its effects are *always* a focus of this treatment, including avoidance symptoms. Trauma is initially addressed from a cognitive perspective to facilitate self-understanding (including the presence and functions of dissociative self-states [DSS]), separate past from present, and reduce trauma-based cognitive distortions that drive self-destructiveness. Many DID patients have significant histories of suicidal, self-destructive and high-risk behaviours (e.g. Brand et al., 2009). Our clinical experience and the expert guidelines suggest that premature focus on trauma memory frequently causes DID patients to develop acute symptom exacerbations with increased suicidal and self-destructive behaviour, sometimes requiring inpatient hospitalization (ISSTD, 2011). Often, this results from unmodified use of exposure-based treatments such as EMDR and Prolonged Exposure or insufficient stabilization.

In making their argument that staged treatment is unnecessary, Huntjens et al. (2019) noted that patients with complex DD (CDD) showed similar, parallel decreases in dissociation as non-CDD patients following inpatient trauma treatment (Jepsen, Langeland, Sexton, & Heir, 2014). However, Huntjens et al. (2019) failed to mention Jepsen's et al.'s critical finding that general trauma treatment did not result in changes in pathological dissociation such as amnesia and identity fragmentation which are hallmarks of DID. Jepsen et al. themselves concluded that treatment that does not directly address CDD may not resolve these enduring pathological dissociative symptoms. Thus, Jepsen et al.'s study does not support the notion that staged treatment is unnecessary or that CDD patients do as well in general trauma treatment as non-CDD patients.

The 'schema therapy' (ST) model described in Huntjens et al. (2019) protocol should be viewed as staged treatment. Their ST provides 16 sessions of unspecified 'psychoeducation', followed by unspecified 'trauma treatment'. This psychoeducation may parallel the emotion regulation and symptom management training in the staged treatment model, such as in the TOP DD Network psychoeducational program, an adjunct to individual therapy, which was associated with stabilization of safety, reduced symptoms and improved functioning in DD patients (Brand et al., 2019).

When they complete their study, Huntjens et al. (2019) need to detail and be specific about the types of adaptations they made to ST for DID patients. They must clarify whether and how they work with DSS, how they handle crises and safety emergencies, and discuss in detail use of adjunctive techniques such as psychopharmacology, journaling, and

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imagery. They need to fully describe their methods for the treatment of traumatic memories.

In their protocol, Huntjens et al. (2019) report they are excluding patients with substance abuse and suicidality, both of which commonly co-occur with DID (e.g. Spiegel et al., 2013). Their criteria restrict the generalizability of their results: a sample that is more stable at baseline than typical DID patients will be more likely to tolerate a truncated period of stabilization. In terms of assessment, Huntjens et al. (2019) do not report regularly assessing depression, conversion symptoms, substance use, self-harm, or hospitalizations.

When they publish the results of their study, Huntjens et al. (2019) should provide a CONSORT chart detailing the number of excluded patients, e.g. the cases whose DID diagnoses were not corroborated by the DID expert. They should identify the number of years of patients' prior treatment, whether they have had prior trauma treatment, and years since DID diagnosis. They must take earlier treatment into account because it may have provided stabilization, including increasing patients' understanding and cooperation among DSS. They should use a DID expert who is familiar with distinguishing genuine DID from factitious cases of DID and cases in which the identity confusion is due to borderline personality disorder rather than DID. The differential diagnosis of these conditions can be challenging and is crucial to ensure reliability of DID diagnoses (ISSTD, 2011). Their follow up must be longer than three months because DID can have a relapsing and remitting course across the lifespan (ISSTD, 2011).

With attention to these considerations, Huntjens et al. (2019) could make a valuable contribution to the literature.

Disclosure statement

No potential conflict of interest was reported by the authors.

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